

0328: MITOMYCIN C GUIDELINES: AN IMPROVEMENT IN DEPARTMENT ADHERENCE THROUGH THE PROCESS OF AUDIT, LED BY JUNIOR DOCTORS

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Introduction: The authors intended to establish adherence to guidelines regarding time to administration of intravesical chemotherapy post-TURBT, in the Regional Urology Unit. EORTC recommends Mitomycin C (MMC) instillation within 6 hours in eligible patients - this reduces recurrence rates by 39%.

Methods: Prospective audit of time to administration in all eligible patients during a 3 month period. Results were discussed at departmental level with a three tiered approach to improvement. Primarily, initiation of in-theatre instillation (Mostafid et al). Second, a training programme for ward staff in handling cytotoxic agents. Finally, awareness of the problem was raised to trainee urologists at the Regional Audit Meeting. A repeat three month audit series was performed six months later. The latter two processes had been implemented with plans for in-theatre administration on-going.

Results: Initially, in 19 patients (40 eligible) the mean time to MMC administration was 18.3hrs (2.3–28.2hrs). 15.7% patients received MMC <6hrs. In the second series of 9 patients (13 eligible), the meantime to MMC administration was 5.2hrs (1–17.25hrs), and 88.9% received MMC <6hrs (none after 24hrs).

Conclusions: Improvement in MMC administration practice is seen following simple interventions led by junior doctors. Through on-going training, adjustment of systems and audit, we hope further improvements can be seen.

0379: AN AUDIT OF UPPER RENAL TRACT UROTHELIAL BIOPSY: OUR INITIAL EXPERIENCE OF BIGOPSY FORCEPS

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Introduction: Biopsy is the gold standard for diagnosis of upper renal tract malignancy. It's always an urologist's challenge to achieve a representative sample for accurate diagnosis. Recent evidence suggests 3mm is the minimal biopsy size required for adequate histopathological diagnosis. We present an audit of our experiences with different biopsy devices.

Methods: 45 patients underwent ureteroscopic/ureterorenoscopic biopsy of urothelial lesions. All biopsies were sent for analysis by a histopathologist with an expertise in urological pathology.

Results: 33 patients underwent urothelial biopsies using the following devices; Piranha(29), reusable forceps(3) and Dormia basket(1). There were 31 ureteric lesions and two pelvicalyceal lesions. Specimen sizes ranged from <1mm (5), 1mm (14), 2mm (8) and 3mm (2). 8 patients required a re-biopsy. Further immunohistochemical analysis (4) and repetitive reviews (4) were required for diagnostic confirmation. 12 patients, underwent biopsies of ureteric lesions (10) and pelvicalyceal lesions (2) using BIGopsy forceps. All specimens were measured >3mm, first time. Unanimous, unequivocal histopathological diagnoses were achieved.

Conclusions: Few biopsy devices provide satisfactory, representative and consistent samples for diagnosis. We experienced an unpredictable outcome with a 25% re-biopsy rate with various devices, however with BIGopsy forceps accurate histopathological diagnoses were achieved with a significant impact on the timely treatment for urothelial malignancies.

0401: HOW CLINICAL AUDIT HAS LED TO REDUCED RATES OF POST TRUS BIOPSY SEPSIS IN OUR TRUST

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Introduction: We recently reported the findings of a regional audit which identified rates of sepsis increasing to 1.8% following transrectal ultrasound guided prostate biopsies (TRUS). Following this audit I.V. Gentamicin 160mg was introduced as additional prophylaxis for patients undergoing TRUS biopsy. Our aim was to assess the impact of adding Gentamicin to the TRUS antibiotic prophylaxis bundle since implementation in August 2013.

Methods: Analysis of all patients who underwent TRUS biopsy across our Trust between August–December 2013 with minimum 1-month follow up. Our findings were compared against our previous audit data and published literature.

Results: There were 246 TRUS biopsy procedures carried out across the Trust following the introduction of our new antibiotic prophylaxis regime. Median age of the population examined was 67 years (range 42–84). Only 1 patient was admitted to Secondary care with significant sepsis (0.4%), 3 patients had positive urine cultures performed in Primary care but did not require hospital admission (1.2%). There were no ITU admissions or mortalities.

Conclusion: We conclude that the addition of I.V. Gentamicin has dramatically reduced the incidence of significant sepsis post-TRUS biopsy. This is an example of how we have utilised audit to modify clinical practice for the benefit of our patients.

0403: PROGNOSIS FOLLOWING PERCUTANEOUS NEPHROSTOMY INSERTION FOR MALIGNANT OBSTRUCTIVE UROPATHY: ONE CENTRE'S EXPERIENCE

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Introduction: Traditionally long-term survival post-nephrostomy insertion for obstruction secondary to malignant uropathy has been variable, however, it is often seen as a manifestation of disease progression. Our aim was to assess patterns of nephrostomy insertion for patients presenting with malignant ureteric obstruction in the modern era.

Methods: We analysed the nephrostomy service provided by our department from January 2011 to June 2013. We focused on the indication of malignant obstructive uropathy with a minimum of 5 months follow up. Each nephrostomy insertion was considered a separate event.

Results: A total of 138 nephrostomy procedures were performed for ureteric obstruction secondary to pelvic or abdominal malignancy (n=138, 68%). There were 46 (33%) female and 92 (67%) male patients. Median patient age was 72.2 (range 42–91) years. Obstruction secondary to prostate cancer (34%) and bladder cancer (34%) were the most frequent indication for intervention. Median survival post-insertion was 73 (range 2–593) days with only 30% of this patient group demonstrating long-term survival. A significant group of patients failed to survive for >30 days post-procedure (n=19, 12%).

Conclusions: Nephrostomy insertion for malignant ureteric obstruction is a hallmark of disease progression. Patients who undergo this invasive procedure often have poor survival characteristics. Each should be counselled carefully before undertaking nephrostomy insertion.

0519: A RETROSPECTIVE AUDIT OF POST TRUSS GUIDED PROSTATE BIOPSY SEPSIS IN A DISTRICT GENERAL HOSPITAL – HOW ADEQUATE IS ANTIBIOTIC PROPHYLAXIS IN THE FACE OF RISING RESISTANCE?

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Introduction: Recent evidence suggests a rising incidence of serious infective complications following TRUSS biopsy associated with significant morbidity and mortality due to fluoroquinolone resistance. This audit aims to determine the incidence of post biopsy sepsis in our hospital.

Methods: We retrospectively reviewed data from a prospectively maintained database of patients who underwent TRUSS biopsy over a 12-month period at our District General Hospital. All patients received the standard protocol of Ciprofloxacin and Metronidazole. We identified patients presenting with symptoms suggestive of sepsis up to 30 days post TRUSS biopsy. We reviewed their case notes to identify the rates of bacteraemia, bacteraemia and hospital admissions.

Results: 319 patients were biopsied and 22 (6.9%) presented with symptoms suggestive of infective complications. 10 (3.1%) had organisms cultured from urine specimens and none had a bacteraemia. Only 2 (0.6%) were admitted to hospital with clinically significant urosepsis, both culturing fluoroquinolone resistant E. Coli.

Conclusions: Although fluoroquinolone resistance may be increasing and urosepsis is a life-threatening complication associated with resistance; our results show it is a rare complication in our unit. Therefore no change in antibiotic prophylaxis is warranted at present. However re-auditing is essential to identifying the reported emergence of clinically significant resistance.

0558: THE INCIDENCE OF UTI FOLLOWING FLEXIBLE CYSTOSCOPY: SHOULD WE CHANGE OUR ANTIBIOTIC PRACTICE?

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